UN HUMAN RIGHTS COUNCIL

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STATEMENT BY PAUL HUNT

SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH
('right to health' or 'right to the highest attainable standard of health')

President, distinguished delegates, ladies and gentlemen,

I took up office as Special Rapporteur in September 2002 and so I will be stepping down later this year. My present report - on health systems - will be my last thematic report to the Council, although I will be completing some country reports in the next few months.

This morning, I take the opportunity to provide the Council with some personal observations, about the right to health, arising from developments since 2002.

Analytical and methodological issues
The right to health is complex and extensive. It encompasses medical care and the underlying determinants of health, such as water, sanitation, non-discrimination and equality.

To make sense of this complexity, I have drawn from the work of many others – including the Council – and refined an analytical framework for 'unpacking' the right to health, with a view to making this fundamental human right easier to grasp. This framework is employed in my thematic and country reports.

One element of this framework is accountability. The right to health demands accountability – not with a view to blame and punishment, but with a view to identifying what works (so it can be repeated) and what does not (so it can be revised).

Right to health accountability is much neglected. In a few weeks time, the University of Essex will publish a monograph on this important topic.[1]

My thematic reports apply the right to health framework to a range of health issues, including maternal mortality, essential medicines, water and sanitation, the skills drain, sexual and reproductive health, mental disability, the health-related MDGs, neglected diseases, international assistance and cooperation, health systems, and so on.

Many other right-to-health issues need urgent attention, such as palliative care. Palliative care includes pain relief for the terminally ill. Every year, millions suffer

[1] Helen Potts, *Accountability and the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 2008 (forthcoming).

horrific, avoidable pain. Very few have access to pain relieving drugs. As always, those in the developing world suffer much more than those in the developed world. Six countries account for 79% of medical morphine consumption. But this is not just a problem of development. Lack of access to pain relieving drugs is partly due to regulatory barriers. Regulations aim to protect populations from drug dependence. But these regulations do not always strike the right balance between this legitimate aim and genuine medical needs. In short, palliative care needs greater attention. Many HIV/AIDS strategies, for example, neglect this critical issue.

11 October 2008 is the World Hospice and Palliative Care Day. This year, the theme is 'Palliative Care is a Human Right'. I urge you to give this issue – and this Day – the attention it richly deserves.

Three of my reports have looked at a major methodological problem. The right to health is subject to progressive realisation. How can we measure whether or not a State is progressively realising the right to health? There is only one credible answer to this question. We need indicators and benchmarks. My third report on indicators and benchmarks sets out a human rights-based approach to health indicators.[2] Of course, this methodology can be improved. But it is no longer possible for a State to argue that there is no way of measuring the progressive realisation of the right to health.

Another report looks at impact assessments. Any modern policy maker, unless purely driven by ideology, will wish to consider the likely human rights impact of a proposed new policy or programme. One of the human rights to be considered must be the right to health. But I found no methodology for right-to-health impact assessments. So my General Assembly report last year sets out such a methodology.[3]

Another chapter in the same report begins to explore the problem of prioritisation. Given finite budgets, how does a Government choose between competing right-to-health priorities?

I have also begun to explore a related problem. The international right to health is subject to 'maximum available resources'. What, precisely, does this phrase mean? Before stepping down as Special Rapporteur, I hope to publish some additional reflections on this important topic. Of course, all international economic, social and cultural rights are subject to 'maximum available resources'. It would be very helpful if a meeting of experts, including economists, provided guidance on what this phrase means. This would encourage a consistent interpretation and help Rapporteurs as they apply the phrase in their respective mandates.

Of course, all these analytical and methodological initiatives are only means to an end. The end - the real goal - is implementation of the right to health.

As I explain at some length in my Council report of January 2007, there is a new maturity about the health and human rights movement.[4] It is developing new tools – indicators, benchmarks, impact assessments, budgetary analysis, and so on. It is not

[2] E/CN.4/2006/48.
[3] A/62/214.
[4] A/HRC/4/28.

just ‘naming and shaming’, taking test cases and organising letter-writing campaigns. As never before, the health and human rights movement is seeking to engage in health-related policy-making in a practical, constructive, operational way.

How to implement the right to health? The critical importance of ‘mainstreaming’.
The classic, long-established health professions can benefit from the newer, dynamic discipline of human rights.

But this is a two-way street.

The right to health cannot be realised without the interventions and insights of health workers.[5]

It cannot be realised without the expertise of those working in medicine and public health.

If we are serious about implementing the right to health, it is absolutely imperative that more health workers engage with human rights.[6] Also, more human rights workers must be willing to learn about health.

I mean no disrespect when I say that a large assembly of diplomats is not the most appropriate - the most promising – group for a discussion on the right to the highest attainable standard of health.

Before becoming Special Rapporteur, I would not have known a neglected disease even if I had caught one. I was unfamiliar with the main components of a harm reduction programme for intravenous drug users, and so on.

I suspect the same is true for many people in this room today.

As I have researched my thematic and country reports, I have listened carefully to health experts and sought to integrate right-to-health considerations into their professional advice. My report on neglected diseases in Uganda, for example, is a blend of health and human rights. It sets out, in some detail, a right to health approach to neglected diseases. My pending report on maternal mortality in India will be equally operational.

With all due respect, I suggest that reports on the right-to-health should be considered not only by the Human Rights Council, but also the World Health Assembly and WHO’s Executive Board.

Over the last six years, I have enjoyed excellent cooperation with a number of WHO members of staff on a range of policy and operational issues. For this, I am extremely grateful. However, to the best of my knowledge, neither the World Health Assembly, nor the WHO Executive Board, have ever considered one of my reports. Despite requests, I have never met a WHO Director General since my appointment in 2002.

[5] By health workers I include all those developing, managing, delivering, monitoring and evaluating preventive, curative and rehabilitative health in the private and public health sectors, including traditional healers.
[6] See A/HRC/4/28.

Of course, this would not matter if the World Health Assembly, Executive Board and so on were considering the right to the highest attainable standard of health in a reasonably systematic way. But they are not.

Frankly, States - and *not* members of WHO's Secretariat - carry the main responsibility for this unsatisfactory state of affairs.

States discuss the right to health here in the Council. They pass encouraging resolutions on the right to health. But, as they journey up the hill from the Palais des Nations to WHO, they appear to suffer from amnesia and entirely forget their discussions, resolutions and legally binding human rights commitments.

The amnesia is of an especially acute form because the General Assembly resolution establishing the Human Rights Council expressly mandates the Council to "promote the effective coordination and the mainstreaming of human rights within the United Nations system".[7]

I urge all States to take steps to mainstream human rights in their health-related national and international policy-making.

In this way, our discussions about the right-to-health will not be restricted to diplomats and lawyers – they will also include health workers, without whom the right to health can never be realised.

As I have argued before, one way for the Human Rights Council to encourage such mainstreaming is by holding a Special Session - or thematic panel - on a right to health issue of global importance, such as maternal mortality and MDG 5. The Council could invite the heads of key UN agencies to share their insights. States could share their good practices. It would not be a technical meeting. But it would have major symbolic and political significance.

A few weeks ago, I understood that there was to be a thematic panel on maternal mortality during the Council's present Session. More recently, I learnt that the panel was removed from the agenda. I hope the Council will look closely at maternal mortality as a human rights issue, either during a regular Session, or in a thematic Special Session.

Health systems

At the heart of the right to health lies an effective and integrated health system that is accessible to all.

Yet in many countries, health systems are failing and collapsing.

In 2006, the Human Rights Council asked me to prepare a report on the key right-to-health features of an effective, integrated and accessible health system. My present report is a response to that request.[8]

[7] A/RES/60/251.
[8] A/HRC/7/11.

In a way, the report reflects my six years experience as Special Rapporteur. It is informed by the right to health analytical framework that I mentioned earlier, as well as numerous consultations with many health workers in several countries. The report endeavours to marry health good practices and the right to the highest attainable standard of health.

In brief, the report identifies a general right-to-health approach to strengthening health systems. It emphasises the importance of transparent, participatory and non-discriminatory processes; the critical role of effective referral systems; the importance of planning, monitoring and accountability; the importance of a minimum 'basket' of health services; and so on.

The report argues that this general right-to-health approach should be applied to the six 'building blocks' that, according to WHO, together constitute a functioning health system – 'building blocks' like the health workforce, health information systems and health financing.

By way of illustration, the report then begins to apply the general right-to-health approach to two of the six 'building blocks'.

The report also argues that, just as the right to a fair trial has helped to strengthen court systems, so the right to health can help to strengthen health systems.

Of course, the relationship between health systems and the right to health is a very large and complex topic that demands much closer study than I was able to give in my report. I hope that the health and human rights communities, working together, will take forward this important issue.

Sweden, India, Ecuador/Colombia, Gaza
Of all those States that I have visited, I am doubly indebted to Sweden.

First, the Government invited me to prepare a report on the implementation of the right to health in Sweden. I presented my Swedish report to the Council in 2007.[9]

Second, I asked Stockholm if I could undertake a second mission – not to look at the right to health in Sweden again, but to look at what Sweden is doing to promote the right to health *outside* Sweden.

Sweden has some very impressive international policies on development, poverty reduction and human rights. They are among the best in the world. I wanted to see how the Government is managing to implement them, in practice, in relation to the right to health. Was Sweden able to translate its fine international policies – its fine words – into action?

To its great credit, the Government of Sweden agreed that I could undertake a second mission for this purpose. So I visited the World Bank and IMF in Washington D.C. to discuss, with the Executive Directors of the Nordic-Baltic countries, how they take

[9] A/HRC/4/28/Add.2.

Sweden's international policies into account in their work. Also, I visited Uganda to examine how Sweden contributes to the realisation of the right to health in Uganda.

May I thank the Government of Uganda for allowing me to visit and conduct numerous interviews in Kampala and beyond.

Although my report focuses on Sweden's responsibilities, it has relevance to all high-income countries.

The international right to health is subject to international assistance and cooperation. In other words, international law gives rise to some human rights responsibilities of international assistance and cooperation in health. The report outlines the contours and content of these human rights responsibilities of international assistance and cooperation in health. It then applies this analysis to the specific, practical context of Sweden's engagement with Uganda, the World Bank and IMF.

Of course there is room for improvement - and the report contains numerous recommendations. However the report concludes that, on the whole, Sweden's programmes in Uganda are broadly consistent with its human rights responsibilities of international assistance and cooperation in health.

Briefly, the Council has before it a Preliminary Note following my mission to Ecuador and Colombia in May and September last year.[10] The mission arose from the invitation extended by the Government of Ecuador to me during the 4th Session of the Human Rights Council (March 2007). The primary aim of the mission was to examine, through the lens of the right to health, the impact of the aerial spraying of glyphosate, combined with additional components, by Colombia along the Ecuador-Colombia border.

I will not repeat here the observations made in the Preliminary Note. However, I take this opportunity to thank the Governments of Ecuador and Colombia for their invitations and cooperation. I will submit to them my draft report, for their comment, as soon as possible.

Briefly, the Council also has before it a Preliminary Note following my mission to India during November-December 2007.[11] The mission focussed on the issue of maternal mortality in Rajasthan and Maharashtra. I will not repeat here the observations made in the Preliminary Note, but take this opportunity to thank the Government of India for its invitation and the support provided before, during and after the mission. My draft report will be submitted to the Government for comment as soon as possible.

Before closing, I must repeat my profound concern about the humanitarian crisis in the Gaza Strip. The health situation is worse than I have previously reported. Today, for example, waste-water treatment plants are near collapse. Hospitals cannot function properly. Medical supplies and services are obstructed. Again, I have to remind donors that their health sanctions have punished the sick, infirm and elderly.

[10] A/HRC/7/11/Add.3.
[11] A/HRC/7/11/Add.4.

Conclusion

In conclusion, I would like to report that I continue to consult, and receive comments on, the draft Human Rights Guidelines for Pharmaceutical Companies in Relation to Access to Medicines that I wrote, and discussed with the Third Committee, last year. I hope to finalise the text before the end of July 2008.

I am extremely grateful to all those who have helped and advised me since September 2002. Of course, it is impossible to mention them all. I am very grateful to UN agencies, in particular UNFPA, UNAIDS and a number of very supportive WHO colleagues. PAHO's support has been outstanding. I am grateful to those States that have invited me to visit, as well as the World Trade Organisation on whom I prepared a report in 2005. Throughout, the support of Brazil and New Zealand has been vital. Civil society's support has been indispensable. I am deeply indebted to the health workers who have patiently educated me about their profession, as well as ordinary people who have shared their time, insights and experiences – some of them painful and personal.

I am also very grateful to a number of funders – I simply could not have undertaken my duties without their financial assistance.[12] I am extremely grateful to a small team of senior researchers and interns at the Human Rights Centre, Essex University. Without my colleagues in the Office of the High Commissioner for Human Rights nothing would have been possible. The professionalism and hard work of my colleagues in Essex and the Palais Wilson has been extraordinary.

Although supported by many, all have respected my independence as an expert accountable to the Human Rights Council.

It would be a dereliction of duty if I did not mention one institutional issue. Funding for OHCHR has increased in recent years and this is very welcome indeed. But funding for special procedures remains a huge problem. What message does it send when a Special Rapporteur, with a global human rights mandate, is expected to do the job after office hours - in evenings and weekends - with the help of one very able, but overburdened, UN member of staff? Such an arrangement is not serious. It is not sustainable.

Nonetheless, I am very grateful to Member States of the Human Rights Council for the opportunity to work with them towards the realisation of one of the primary purposes of the UN - as set out in article 1 of the UN Charter - the promotion and protection of human rights for all.

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17/03/2008

[12] The Canadian International Development Agency (CIDA), European Commission, UNFPA, Joseph Rowntree Charitable Trust, Ford Foundation, Open Society Institute, British Medical Association, the International Federation of Health and Human Rights Organisations, and WHO.